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Perspective

Implementation and Enforcement of Health Care Reform — Federal versus State Government

Timothy S. Jost, J.D.

Health care reform lurches forward. The House and Senate have both passed reform bills. How well reform works in practice, however, will depend on one key difference between the two bills that has received far too little attention — how their provisions will be implemented and enforced.

The essential frameworks of the House and Senate bills are quite similar: both include health insurance and underwriting reforms, insurance exchanges, subsidies to make insurance affordable, individual mandates, and penalties for large employers who fail to insure their employees. Yet their approaches to oversight and enforcement, and in particular to the respective roles of the federal and state governments, differ substantially. As we look back a decade from now, whether we see the vast majority of Americans benefiting from ready access to uniformly fair and affordable health insurance or a national patchwork, with some states ensuring access to affordable health insurance for most residents while other states leave many uncovered, will depend largely on whether the final legislation is closer to the House or the Senate approach.

In sum, the House bill creates a new federal program implemented and enforced consistently throughout the country by a new federal agency, the Health Choices Administration (HCA), in cooperation with the states. The Senate bill takes a bifurcated approach. Primarily, it depends on the states to adopt the federal insurance reforms as their own law, establish their own exchanges, and under federal supervision but without ongoing federal financial support, implement and enforce the law themselves. But alternatively, the Senate lets the states opt out of national reform altogether, creating their own reform programs.

The House's HCA would have primary responsibility for administering the regulatory and subsidy programs established under the bill. The House bill would establish a national insurance exchange, which would be responsible for negotiating and enforcing agreements with insurers. It would also create a national public insurance plan.

Recognizing the important ongoing regulatory role of the states, however, the House bill would not supersede state laws that do not conflict with it. The states would be primarily responsible for insurer licensure and solvency and would continue to enforce their own laws as to marketing, claims practices, consumer protection, and most other functions that they now regulate, except insofar as state laws came in conflict with new federal requirements. The federal government would conduct audits of health plans in cooperation with the states, and state attorneys general could enforce the federal law. State-law remedies against health insurers would be preserved. States would have input into the secretary of health and human services' definition of the essential benefits package and could decide whether to enter into interstate insurance compacts.

The House bill would even permit a state to operate its own insurance exchange, but only if the HCA determined that it met specific requirements. If a state opted out of the national exchange, the HCA could retain enforcement authority and could terminate the state exchange if it ceased to meet federal requirements. A state that opted out would have to provide matching funding to establish its own exchange; otherwise, the federal government would pay the full cost of operating the national exchange in the state.

The basic model under the Senate bill, by contrast, would establish a hierarchy between the federal and state governments. The primary responsibility of the federal government would be to draft regulations and then to monitor state compliance. The states would have to enforce the federal law as well as their own laws. Only if the federal government determined that a state would fail to implement the insurance reforms by 2014, or at the state's request, could the federal government implement the reforms directly or set up a federal exchange in that state. Under the Senate approach, some states might choose to allow federal implementation of the law, but the expectation would be that the states would enforce the law themselves. If a state turned over implementation to the federal government, that implementation would be further delayed.

The Senate bill also incorporates an alternative model. It gives the states opportunities to opt out of the national reform program. A state would be allowed to create its own basic plan for residents with incomes from 133 to 200% of the federal poverty level, if it were willing to cover eligible persons for only 85% of the amount that the federal government would otherwise have paid for coverage (in the form of tax credits for premiums and cost-sharing–reduction payments, or "affordability credits"). Furthermore, after 2017, with federal permission, states could opt out of most of the remaining requirements of the legislation (including the individual and employer mandates and the provisions regarding affordability credits) to pursue their own reform programs. If this option were widely followed, of course, it would destroy the national scope of the reform program.

Perhaps most important to the states, these enforcement and exchange responsibilities are an unfunded mandate. The Senate legislation would provide the states with start-up funding for the exchanges, consumer assistance, and premium review, but once the legislation was implemented, states would be on their own. Moreover, the federal government would administer the affordability credits, which would not pass through the states (except in states with waivers). The states would not, in any event, have access to this money for carrying out their responsibilities.

The Senate bill is no doubt intended to show deference to the states, but the House bill is in fact more in line with the traditional relationship of cosovereignty between the federal and state governments. The House bill recognizes the states as partners, not as either underlings or wholly independent sovereigns. In my view, the House approach would result in effective, uniform, national implementation of the reform legislation, whereas the Senate bill is likely to get mired in state political battles. Each state would have to enact the federal laws as its own — and thus would begin 50 state reenactments of the battle we have witnessed all year in Congress.

We have tried state implementation of federal health care reforms before, and the results have often been discouraging. The Senate approach is precisely that taken by the Health Insurance Portability and Accountability Act (HIPAA) insurance reforms of the 1990s, and though HIPAA's reforms to group insurance were successfully implemented, implementation of the individual insurance reforms was faltering and incomplete.[1] Although Medicaid, another joint federal–state effort, has proved successful in extending coverage to poor Americans, it has also resulted in a continual tug-of-war between the federal government and the states over funding and control.[2]

Moreover, there is every reason to believe that state implementation of federal reforms would be even more difficult this time around. Arizona has already placed on its ballot for next year a constitutional amendment opposing implementation of health care reform on its soil, and 11 other states are considering following suit.[3] Finally, most states are in desperate financial straits and in no position to take on major new obligations for implementation and enforcement.

In the end, it is not just the reforms we adopt but how we choose to implement them that will matter. The Senate bill undoubtedly reflects the Senate's reading of the political landscape, but I believe that the House bill is much more likely to result in more effective and consistent implementation of national health care reform.

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From the Washington and Lee University School of Law, Lexington, VA.

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